

Return Application With  
Check Payable To:  
**Treasurer – State of NH**  
  
Annual Licensing Fee:  
**\$250**

**State of New Hampshire**  
**Board of Pharmacy**  
121 South Fruit Street  
Concord, NH 03301-2412  
Tel.: (603) 271-2350 Fax: (603) 271-2856  
Website: www.nh.gov/pharmacy

Board Use Only (Do Not Write In This Box)

**July 1, 2015 – June 30, 2016**  
**Registration Period**

**LIMITED RETAIL DRUG DISTRIBUTOR**  
***METHADONE MAINTENANCE / DETOXIFICATION FACILITY***

(NH Department of Health and Human Services Certified Alcohol / Drug Disorder Treatment Provider)

<b>Clinic Name &amp; Address: (Actual Licensed Location)</b>						
Clinic Name						
Street Address						
City		State		Zip Code		
Telephone:	Fax:	DEA Registration # <b>(Attach Copy)</b>				
Parent Company (If Applicable):						
Controlled Substances On Site: <input type="checkbox"/> Methadone <input type="checkbox"/> LAAM <input type="checkbox"/> Buprenorphine		Current NH HHS Certified Drug Treatment Provider Certificate #: <b>(Attach Copy)</b>		Security: <input type="checkbox"/> Audible <input type="checkbox"/> Motion  Signal To:		
Applicant's Proposed Drug Activity: <b>(To bona fide patients of clinic only)</b> <input type="checkbox"/> Administer <input type="checkbox"/> Dispense "Take Home" Available: <input type="checkbox"/> Methadone <input type="checkbox"/> Buprenorphine			Drug Supply: <input type="checkbox"/> Bulk <input type="checkbox"/> Prepackaged* *Prepackaged By: _____ Location: _____			
<b>Name Of Owner(s): (Indicate Individual, Partners, Etc. - If Corporation, Show Title Of Officers) Attach Additional Sheet If Necessary</b>						
Name		Address			Title	
Name		Address			Title	
<b>Has registration or licensure granted to the applicant by any state or federal agency ever been suspended or revoked?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(If "yes", attach a detailed description).</b>						
<b>Provide the information below for the person responsible for the operation of the clinic:</b> (The permit & future renewals will be directed to this person)						
Name:		Title:		Tel. #:		
Business Mailing Address:						
<b>Hours of Operation</b>						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Provide name(s) of person(s) in charge of drug purchasing, dispensing records and security. (Use Reverse Side if Necessary)</b>						
<b>Medical Director:</b>						
Name		Address			Telephone Number	

**APPLICATION CONTINUED ON NEXT PAGE** ➡

**Practitioners: (Use Reverse Side If Necessary)**

Name:	Title:	Name:	Title:

**Consultant Pharmacist:**

Name	Consultant's Signature (Applications without consultant's signature will be returned unprocessed)	NH License No.

**Declaration And Signature By Clinic Representative:**

I have attached the following required documents:

- ☐ A copy of the clinic's *Current NH DHHS Certified Drug Treatment Provider Certificate*.
- ☐ A copy of the clinic's current *DEA Registration*.

I declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the permit herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State. To the best of my knowledge, myself nor any of the employees, listed on this application, have been arrested, investigated for, charged with, convicted of, sentenced, entered a plea of non contendere, or entered into any other legal agreements for any criminal offense in any state, territory or possession of the United States or by the federal government.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
(Responsible Party) (Indicate whether owner, partner, or officer of corporation)

**THE LICENSEE SHALL NOTIFY THE BOARD WITHIN 15 DAYS, IN WRITING, OF ANY  
CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.**

**ALL QUESTIONS ON THIS APPLICATION MUST BE ANSWERED AND COPIES ATTACHED OF DEA REGISTRATION &  
NH HEALTH & HUMAN SERVICES CERTIFIED DRUG TREATMENT PROVIDER CERTIFICATE**